

Medical History for:

First Name	Middle Initial	Last Name	Date of Birth	Phone
Address	City	State	Zip	Email

Physician (Include first and last name if possible):

Physician Office Location/Contact number:

Date of Last Physical:

Are you under a physician's care? YES NO

If so, why?

Have you ever had an operation? YES NO

If so, for what and when?

Do you have any artificial joints? YES NO

Do you have a heart murmur? YES NO

Do you have an artificial heart valve? YES NO

Have you ever had Rheumatic Fever or Rheumatic heart disease? YES NO

• Women: Are you pregnant? YES NO

• Women: Are you taking Birth Control? YES NO

Do you have, or have you ever had any of the following:

A. Anemia YES NO

B. Arthritis YES NO

C. Asthma YES NO

D. Diabetes YES NO

E. Epilepsy YES NO

F. Fainting Spells YES NO

G. Hay Fever YES NO

H. Heart attack YES NO

I. Hepatitis YES NO

J. High Blood Pressure YES NO

K. Hives or a skin rash YES NO

L. Jaundice of Liver Disease YES NO

M. Kidney Trouble YES NO

N. Low Blood Pressure YES NO

O. Seizures YES NO

P. Stomach Ulcers YES NO

Q. Stroke YES NO

R. Are you sensitive to metals and/or latex? YES NO

S. Do you have a pacemaker? YES NO

T. Have you tested positive to HIV? YES NO

U. Bled excessively after surgery or extractions? YES NO

V. Have you ever had a blood transfusion? YES NO

W. Have you ever had radiation or chemo? YES NO

(Please continue and finish Medical History form on backside)

Current Medications

Please list **NAME** of medication, **DOSAGE**, and **REASON** for medication:

1.	5.
2.	6.
3.	7.
4.	8.

Are you allergic to, or have you ever reacted adversely to, any of the follow?

Penicillin	YES	NO
Sulfa	YES	NO
Other Antibiotic:	YES	NO
Barbiturates, sedatives or sleeping pills	YES	NO
Local Anesthetics	YES	NO
Aspirin	YES	NO
Ibuprofen	YES	NO

Any Other? _____

Dental History

Name of previous dentist/dental practice: _____

If you are a **New Patient**, date of **Last Dental Exam**: _____

Have you ever had any **serious trouble associated with previous dental treatment**? YES NO
If so, **what**?

Have you ever had **orthodontic treatment (braces)**: YES NO

Been treated for **gum disease (gingivitis, periodontitis, pyorrhea)**: YES NO

Do you **grind or clench your teeth**? YES NO

Do you **smoke, chew, use snuff or any other forms of tobacco**? YES NO

Have you had a **skin reaction to rubber products or latex**? YES NO

Have you had any **injuries to your mouth or jaws**? YES NO

Have you been **satisfied with your previous dental care**? YES NO

If not, please explain:

Is there anything else we **should know about your health that we have not covered on this form**?

YES NO

If YES, please explain:

Signature

Date

Dental Insurance Plan Information: Name of Insurance Plan _____

Subscriber Name: _____ Subscriber's Birth Date: _____

Subscriber ID # or Social Security # _____ Group # _____

Ins. Mailing Address: _____

Phone # _____ Employer: _____